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Recovery Begins with Hope

Su Maddock and Sophy Hallam

Supported by

Centre for Mental Health

Recovery Begins with Hope

Su Maddock and Sophy Hallam

Foreword from Jonathan Kestenbaum

Some might say that now is not the time for innovation in public services, that we just need to 'get through' the next few years before we can consider new ways of doing things. But the immense and growing pressures facing our public services – from saving money to coping with ever-increasing demands – only reinforces the need for imaginative new approaches, starting now. Innovation is an important part of the answer to today's challenges, as well as tomorrow's.

This valuable report, focusing on an innovative approach in mental health services called 'recovery', demonstrates that radical change is possible within mainstream public services. It also exemplifies a range of interesting paradoxes about this type of innovation.

The issue of mental illness (or as the authors might prefer, wellbeing) is of course a deeply personal one, but it is also a massive social issue with huge costs to our economy and society. It is appropriate then that the recovery approach is both very personal – based on practitioners working in equal relationships with users of mental health services – but also that it has a wider significance for how we organise many of our public services.

Talking about the importance of public services that 'build relationships' might seem somewhat esoteric given impending budget reductions, but in fact it represents a crucial way in which services could be much more effective and so significantly more cost-effective.

While it has strong theoretical roots, crucially recovery is not just an abstract theory. This report shows how it can be done and the benefits that it brings. Approaches such as recovery start with listening to the 'lived experience' of service users as people, yet as this report shows, the wider adoption of such approaches depends on leadership and support for frontline staff.

Mental health might often be regarded as a 'Cinderella service', but the work that has been done here is important for public services. Indeed, it could be crucial to their renewal.

Recovery Begins with Hope and Opportunities

This report is extremely relevant to the personalisation of services. It shows how two public employers put an innovative form of personalisation called 'the recovery approach' into practice. The essence of the recovery approach is to give personal control, hope and opportunities to those experiencing mental distress – the challenge is that it demands a radical change in attitude to mental illness and to those suffering from it.

Currently, there is a strong interest in the benefits of mutual support and the personalisation of services but very little evidence on how existing services staff can change their attitudes and relationships with service users. The significance of this study is that it demonstrates how service providers could switch from cold 'custody and care' to more mutual and appreciative support' by aiming to help people recover rather than decay – to do this mental health staff need to appreciate the experience of mental distress and start to believe that 'recovery' is possible.

The implications of the report are that personalisation in any service starts from an appreciating 'the lived experience' of the service recipient and recognising that this person has the potential to become a 'peer support' for someone else later. This is as true of substance mis-users and offenders as it is of mental health sufferers. The study shows that successful implementation of more innovative forms of personalisation depends on innovation champions, whose journey of campaigning, collaboration and implementation starts from a belief in people and their capacity to hope, learn to relate and reorganise their lives.

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Executive Summary

The pressure on government to provide personalised services and The Big Society makes 'the recovery approach', based on hope and opportunity a significant innovation that could be applied, not just to mental health services but to all those services seeking to help people recover from drugs, offending and the demoralisation of unemployment and worklessness. It offers commissioners a model for service provision that encourages mutual support from peers and opportunities and personal development from practitioners. What has held back mutual support and co-production has been the lack of know-how and capacity among service providers, particularly in mainstream services such as mental health; this study addresses that gap and outlines how NHS mental health trusts are integrating the recovery approach in all their adult services and giving people with mental health problems a future and a life.

The recovery approach radically humanises the professional/user relationship and expresses the voice and experience of those who live with mental distress. The mental health recovery group 'Rethink' have reported that a recovery journey starts with 'a safe place to live, a sense of personal control and basic human rights'[1]. The recovery approach emphasises co-design and mutual support and as such the Big Society agenda.

That there is a better way of supporting those living with mental illness is undisputed – not only are existing services costly and inadequate, one in four people suffer from mental distress at some time which impacts on them, their families, communities and productivity. GPs are at a loss as to how to treat those suffering stress, breakdowns and acute mental illness and we do not understand the individual causes of mental illness or how to provide the sort of care that would support recovery or good mental health. 'Recovery' is not a panacea, but it does provide a practical model of rethinking and redesigning a whole range of services that impact on those experiencing poor mental health.

This has huge implications for mainstream adult mental health services and demonstrates how personalisation has to be more than choice and demands a radically different mindset among staff, particularly among clinicians. However, while a new social enterprise that employs people with mental health disorders may co-design services, it is harder for established professional and institutional bodies to change their thinking and behaviour.

1. Getting back into the world; reflections on the lived experience of recovery (2010) www.rethink.org/intotheworld

It has become widely accepted that creating new service delivery models is easy, it is putting them into practice that is hard. This is significant as it is mainstream adoption that is the obstacle to diffusing innovations such as 'recovery'.

Given this fact, the authors are not arguing the recovery case, but instead recording the stories of 'recovery champions' who have been effective in winning the policy argument and are now putting 'recovery' into practice within adult mental health services. The fact that the *Centre for Mental Health* had set up a network of NHS Trusts embarking on embedding the recovery approach provided us with a golden opportunity for working alongside innovative practitioners in two NHS mental health trusts, one in Devon the other in London.

We found that sustained leadership was critical in the early adoption of the recovery approach as an innovation in mental health services. This was followed by systematic training and staff involvement, the employment of 'peer support workers' and importantly collaboration and networking with other services and with service users across each locality. Those in executive positions play a critical role in creating the space for blurring the boundaries between all staff and service users, orchestrating partnerships, transforming corporate functions such as HR, training and performance management and promoting a positive message that recovery is part of the wellbeing agenda.

The trusts involved were spawning social enterprise, transforming commissioning and understanding within professional bodies. They were not however complacent and recognize that they were themselves in the early stages of recovery from institutionalisation. Their work and experience of embedding 'recovery' thinking across their organisation and within other service organisations and commissioning is changing the way they work and has implications for all personalised services.

This approach can change not only the lives of those seeking support but also staff, families and other professionals. Too many services are unresponsive because staff have low aspirations and are not confident that they can make a difference.

We all live through good and bad times, the worse thing that can happen to a person it that others around them assume that they have no future, that they are trapped and stigmatised for life. The more that the recovery approach gains momentum the more that it will lift all personalised services out of care and custody into learning and recovery.

Communities and families play a big part in this process, but mainstream services are essential to creating the conditions for more positive social relationships between people and with staff in a wide range of services. Only then will there be more seamless support into learning, health, jobs etc across the country; then perhaps mental health will be seen as part of societies' 'wellbeing' agenda.

Introduction

This report focuses on how the recovery approach in adult mental health could radically improve people's lives and make dramatic savings in the longer term.

The study is timely. The fact that innovation in mental health services is necessary is undisputed. There are few who deny that existing mental health services do not work. Most people experience mental trauma some time in their lives but in spite of this public attitudes and services have been slow to change. All personal services have improved over the past ten years but few have radically transformed such that they recognise the experience of service users, in this instance people with mental disorders.

The recovery approach is based on the core principles of respect, hope and opportunity, which could apply to any 'personal' service. These principles create confidence and raise expectations not just of service users but also of staff. 'Recovery' shifts the emphasis from diagnosis towards recovery and wellbeing because a person's hopes are usually the biggest influence on their capacity to recover from mental disorder.

The recovery approach provides hope for those suffering mental distress and radically changes the staff/patient relationship. 'Recovery' involves a set of principles that humanise the relationship between clinician and 'client'. As an approach it illustrates the common features of public service innovation, it is based on people's life experience, it focuses on a positive relationship between service giver and recipient and unites many services in a common cause of the person seeking help.

Those suffering with mental disorders have been advocating a recovery approach for many years, but as yet there has been little to suggest how to mainstream it in adult services. Recovery champions are not suggesting that 'recovery' is a panacea or an alternative to clinical treatment but that it offers more positive ways of supporting those with mental illness and others undergoing difficult transitions in their lives.

Too often those in policy ignore the HOW to make change. As with many service innovations the argument for 'recovery' has been won, the question is how to mainstream or embed in adult services.

This study focused on the ***how to*** rather than the model itself and records the journeys of two NHS mental health trusts that have adopted 'recovery' as an approach in their policies and are now attempting to put it into practice.

1. Context

1.1 Context post general election

The Coalition Government's 'Big Society' shifts the emphasis from the state delivering innovative public services towards the capacity of local people organising themselves. The problem for all political administrations had been how to embed and mainstream services which are capable of not just responding to the public, but actually involve the public and individual service users in the ethos and delivery of service.

Mutuals, social enterprise and co-production have long been embraced by those wanting to rebalance the relationship between state and the individual. This is a long tradition in the UK. In the late 1970s people set up tenants organisations, childcare, advice centres and hostels because services at the time were limited and very unresponsive. New Labour picked up this agenda and expressed it in the 'Third Way' – they were emphatic about the need for responsive services, but failed to see the impact of centrist, top-down mechanisms on a local staff's capacity to deliver such change. People have always been frustrated by bureaucratic responses especially when the state becomes overbearing in its diktats and organisation. The trouble is that sometimes the desire to break down barriers throws 'the baby out with the bath water'. Creating an environment for innovation is necessary; this is not a mandate for no government but more a question of government's role in supporting those in locality commissioning and leadership already engaged in user-centric services and starting to develop platforms that stimulate community mutual enterprises or social organisations.

Granfield and Cloud[2] talk about recovery capital which acknowledges that those with the most social capital are the most likely to be able to draw on a range of resources that will help their recovery, whatever type of personal trauma or transition they are experiencing.

2. Granfield and Cloud (2001) Social context and 'natural recovery'; the role of social capital in the resolution of drug associated problems, substance use and misuse. Vol 36.

1.2 Mental health policy context

Unfortunately, GPs are overwhelmed by people seeking help with mental health disorders. Yet services are patchy or non-existent, many people wait months for treatment or never receive any support. In September 2009 less

than 10% of the public experiencing mental health problems received any treatment at all[3].

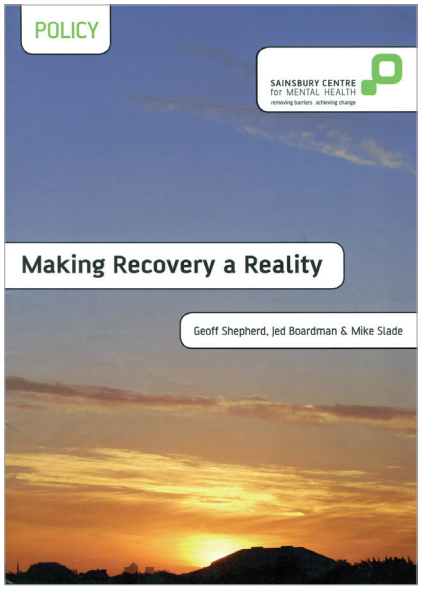
A growing number of mental health practitioners believe that a radical change in services is essential and that better outcomes can be achieved when services are delivered in co-operation with people who live with mental distress who are able to determine their care and understand their recovery care plan. The Care Quality Commission (CQC) published their survey of NHS mental health inpatients and found that only a third were involved in decisions about their own care and treatment, many were denied access to 'talking therapies' and few understood the side-effects of their drugs[4].

The Department of Health is now explicitly encouraging recovery-oriented services[5] and mental health professionals in medicine and nursing have also endorsed their value[6]. The adoption of 'recovery' within mental health policy is consistent with the previous government's emphasis on 'personalisation' and is clearly in tune with the Coalition's government's 'Big Society' ethos and more personal services as a way of driving efficiencies and wellbeing.

There is a growing frustration among GPs and patients and that existing mental health services were not working, even though recovery rates for mental illnesses are good. A study by the National Association for Mental Health showed that there was a 60% recovery rate for schizophrenia, 80% for bipolar disorder, 65-80% for major depression, and 70% for addiction treatment: people usually recover from mental trauma when they are engaged in productive activity and their doctors' expect them to recover.

The Mental Health Trust Network has been advocating recovery-oriented services for some years. Together with the Royal College of Psychiatry and practitioner networks it has been instrumental in the former government adopting the concept of 'recovery' in mental health policy. The Centre for Mental Health policy paper[7] Making Recovery a Reality and subsequent paper in 2009[8] were the basis for the Centre for Mental Health's contribution to The Department of Health's Constitution on Mental Health – New Horizons (2009)[9] which specifically endorses the value of recovery principles for those with enduring mental health problems. New Horizons acknowledges a link between poor mental health and social exclusion and the wider impact that episodes of mental illness can have on people's lives, jobs and relationships.

3. Royal College of General Practitioners (RCGP)
4. Care Quality Commission CQC 2009 Survey on NHS mental health inpatient in England.
5. The Journey to Recovery – the government's vision for mental health care. London. Dept of Health (2001)
6. From Values to Action; the chief nursing offices' review of mental health nursing. London. HMSO& RCP/SCIE/NIMHE (2007)
7. Making Recovery A Reality Policy paper Geoff Shepherd, Jed Boardman & Mike Slade (2008)
8. Implementing Recovery – a new framework for organisational change (2009)
9. New Horizons: A Shared Vision for Mental Health (Department of Health 2009)



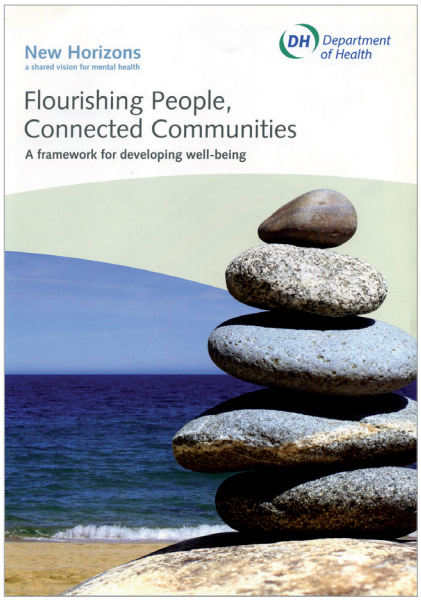
Front cover of the Centre for Mental Health report 'Making Recovery a Reality'

'It is important that all staff... have the necessary knowledge, skills and attitudes to deliver interventions and approaches that challenge stigma and discrimination and improve the quality of care, social outcomes and mental wellbeing across all ages and communities... Good clinical and professional leadership is key to driving forwards service quality at the local level.'

Shepherd, Boardman and Slade (2008) identified the critical factors involved in implementing recovery. As well as helping them to manage their symptoms, mental health trusts are being called upon by commissioners to respond to the wider social and economic exclusion and stigmatization that people with mental health problems often face.

'People with mental health problems should receive high-quality, personalised care based on recovery principles, whether in hospital or the community . Recovery is about building a meaningful and satisfying life, as defined by the person themselves. Hope is central to recovery and can be enhanced by a person having more active control over their life.'

Both quotes taken from Department of Health's Strategy for Mental Health New Horizons: A Shared Vision for Mental Health (2009)



Front cover of Department of Health's Strategy for Mental Health New Horizons: 'A Shared Vision for Mental Health'

2. The Recovery Approach

2.1 Why recovery is an innovation

Recovery is a process rather than a state of mind and could be said to be a quest for a better life or future. In the USA the Betty Ford Consensus Panel defined recovery as *'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship.'*[10]

Best and Laudet (2010)[11] say for substance misusers "the essence of recovery is a live experience of improved life and sense of empowerment…and that the principles of recovery focus on hope, choice, freedom and aspiration."

In mental health, the recovery approach, while not new, is innovative because it shifts the emphasis from diagnosis to recovery, and states that people with experience of mental disorders are the experts. Those around them can help them best by fostering a belief that they can rebuild a meaningful life after being unwell, and by supporting them to do so. Self management and support from friends and fellow sufferers is the key to the process. Clinicians are there to be 'on tap, not on top', moving away from being expert to being 'coaches' on a journey of recovery. The recovery approach, with its three principles of hope, agency (i.e. 'control') and opportunity places those with the 'lived experience' of poor mental health at the centre of care.

"Recovery is not a treatment, although it may well be supported by the careful deployment of evidence based approaches. Its meaning has to be found and nurtured by individuals and families. If we are going to be more interested in supporting people in recovery and in their social inclusion than in treating them, we will need to widen our vision to include an intimate and growing understanding of the lived experience of mental disorder and how people have overcome its limitations."[12]

Roberts and Hollins

The recovery approach has been adopted not just in mental health but also within substance misuse services where mutual support is seen as being critical to recovering a life. Within mental health services 'recovery' has become more accepted within some fields of psychiatry such as learning disabilities, forensics and therapies than in adult general psychiatry and by those treating in-patients who continue to focus on diagnosis rather than recovery, and on patient safety and risk rather than personal responsibility.

10. Betty Ford Institute Concensus Panel (2007) 'What Is Recovery? A Working Defiition from the Betty For Institute', Journal of Substance Abuse Treatment, Vol 33, pp221–228
11. Best, D. and Laudet, AB. The Potential of Recovery Capital (2010)
12. Glenn Roberts and Sheila Hollins – in Advances in Psychiatric Treatment 2007 Vol 13 http://apt.repsych.org

13. Recovery Initiatives Within the Lambeth South-West Sector, August 2009

Conventional services have tended to silence people rather than help them recover.

'The bulk of recovery work takes place at an individual level between care co-ordinators and their service users... My own sense is that we need to move towards more of a partnership model and away from an expert professional mode'[13]

Dr Jerome Carson, consultant clinical psychologist, SLAM

'Recovery' supporters, such as Dr Carson believe that mental health services need to be open and collaborative with service users and design recovery plans in response to individual needs. To do this well, they need to work with other services so users can access the wide range of services that will help them rebuild their lives.

The recovery approach gives people an identity beyond being a mental health patient as someone who can aspire to having a job, a future and plans. However anyone who has been through a period of mental trauma knows that it results in a loss of ability to do many things such as holding down a job, maintaining relationships with those they love, meeting with friends or paying bills. 'Recovery' implies an intensely personal journey that has to be led and shaped by the person themselves as they learn how they can protect and enhance what keeps them well, and minimise what makes them unwell. The role of staff is to work alongside people and help them come to terms with a changed internal landscape after episodes of mental ill health, at the same time as helping them to find new opportunities for training, friends, getting a job or a house.

'Recovery' is not just patient-centred. It is based on a belief that more optimistic psychology among the public and practitioners will lead to a more positive approach to mental disorder and a wider range of services that will help them recover. Those trapped under the weight of negative assumptions about themselves rarely think highly of themselves. Such negativity undermines confidence in making any sort of recovery and reinforces not only a negative dynamic but perpetuates the popular belief that mental illness blights a person for life. This is not an unusual dynamic in many residential institutions in the UK.

'If you weren't despairing before entering mental health services that refused to acknowledge you as a person, you would certainly become so whilst there.' **Gene Johnston, Recovery Innovations**

There is a strong belief that those who have already experienced mental trauma are the best placed to work alongside those experiencing similar difficulties. They have become known as peer support workers. In the USA, Australia and New Zealand, employing peers as support workers is seen as the key to generating more positive internal cultures and that for this to emerge a critical number of peer-support workers are necessary. 'Recovery' has become a form of co-production within mental health services.

2.2 The mental health recovery movement

The recovery movement have been active in championing the need for much more user-centric mental health services, in the USA, New Zealand and Australia and more recently in Europe. Mary O'Hagan was a significant champion in New Zealand and is now mental health policy leader for the NZ government. She was previously the chief architect of the Blueprint for Mental Health Services in New Zealand (1998)[14]. She and others have influenced practitioners in the UK who have learnt from the independent service providers and social enterprises in these countries that one way to combat stigma and low expectations is to employ those with experience of mental health problems.

Eugene Johnston, President and CEO of Recovery Innovation in Arizona describes the underlying philosophy of the recovery approach as a faith in people and the power of personal belief in regaining confidence in the future. He believes that people's beliefs drive their actions: what they believe about their illness will shape how they respond and can give rise to either hope or despair. He suggests that those working in mental health services need to act in a way which helps inspire hope in the people they care for that things can get better, and that this can increase their chances of regaining, or rebuilding a meaningful life.

14. Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998)

3. The Study

3.1 An opportunity to research innovation in mental health

The fact that the Centre for Mental Health had initiated a network of NHS Mental Health Trusts that were serious about implementing the recovery approach provided the authors with an opportunity to track how it was being mainstreamed within particular localities. We wanted to explore the implementation process and how these Trusts were going about putting 'recovery' into practice.

Previous research (Maddock & Hallam 2002)[15] showed that success in incorporating public service innovation into mainstream services often depends on the persistence of champions and the backing of senior leadership and their ability to tell a story to staff and other partners about why this change is necessary, how it benefits service recipients or the public and how they will be rewarded if they change their behaviour is particularly important.

The study was an iterative, light touch and qualitative – informed by the Centre for Mental Health Steering Group and the wider 'recovery' network. The authors were invited to meet with the Centre for Mental Health Steering Group, which included NHS Mental Health Trusts in Hertfordshire, South London, Sussex, Devon and St George's in Tooting Bec to discuss the factors they considered relevant to recovery implementation.

Their involvement was invaluable and after discussion we decided to track two Trusts in particular: the South West London & St George's Mental Health NHS Trust (SWL & STG) and the Devon Partnership NHS Trust (DPT) while making reference to developments in other places and with the wider network. The Centre for Mental Health steering group and network provided access to current thinking and practice in recovery and also opportunities for conversation about the obstacles to implementation.

15. Innovations in Emergency care – The Primary Care Physicians Emergency Care Scheme, Dr. Su Maddock and Sophy Hallam, NW Change Centre, Manchester Business School, 2002

We noted Gene Johnston's criteria for assessing whether staff are open to the experience of those with mental health problems or not, such as whether

- practitioners and staff believe in recovery and in people holding the key to their own destinies
- recovery training is regularly given to all staff
- staff are connected to the realities of mental health problems and have empathy
- the Trust employs peer support workers
- there is training for peer support workers

And decided to incorporate the above questions in our interviews, alongside those relating to our interest in

- the Trust's Leadership and champions, their values and strategies
- Trust Board and commissioner engagement
- local partners and collaboration
- staff and managers attitudes and actions
- strategies and ways of working with staff, service users and other agencies.
- service user networks and views of those with the lived experience of mental disorder.

3.2 Contexts and incentives for change

The NHS Mental Health Trusts in Devon and South West London are located in very different contexts, one rural, the other cosmopolitan. Both Trusts experienced crises in the late 2000s, and had recruited new Chief Executives who galvanised their Boards to take the recovery approach seriously. In Devon, a serious clinical incident resulted in a loss of public confidence in the Trust, and in London a very poor National Patient Survey shocked the

16. 2006 White Paper 'Our Health, Our Care, Our Say' (DH)
17. 2007 report 'Breaking Down the Barriers', Louis Appleby (DH)

SWLSTG Board, because they had previously been viewed as a high-performer and a leader of innovation in community mental health services. These crises created a mandate for change and provided key champions of the recovery approach who influenced the type of change and way it was introduced.

The recovery agenda was part of their strategies to tackle these challenges in a way that would reshape services in a manner more in tune with the direction being signalled by Department of Health national policy guidance.[16 & 17]

Image taken from Beyond the Storms edited by Davidson and Lynn and published by the Devon Partnership Trust 2009

4. The Devon Partnership NHS Trust

4.1 Leadership and strategy

18. DPT strategy document

A commitment at the executive level to 'Put Recovery at the Heart of What We Do' has become one of the Devon Partnership Trust's (DPT) key objectives. The DPT Board takes the view that being guided by their service users to do the right thing will also help them deliver on mental health policies and targets.

'In everything we do, we should be asking ourselves 'is this service good enough for my family'? Where it is not good enough, we must encourage our staff and others to say so and, importantly, provide the support and tools to make the changes that are needed. If we are to deliver upon this ambition and consistently provide services that are good enough for our own families, the services must be safe, personalised, timely, recovery-focused and sustainable. These five objectives will underpin all of our activities.'

Iain Tulley, Chief Executive, DPT[18]

A number of different developments were identified as having influenced the Trust in its decision to adopt recovery-focused practice. The practice manager for the Trust spent six months in New Zealand and returned to run an international conference on 'recovery' which attracted eminent international speakers and raised the profile of the approach locally. The Community Care Trust, an independent voluntary sector organisation, was already offering a more recovery-focused service under contract to the Primary Care Trust (PCT). Colleagues and practitioners were keen to explore how the PCT was able to offer recovery-focused care and see how they could bring this approach into the mainstream of the DPT.

DPT aims to improve the quality of care available in the county and to deliver services which are more joined up and better signposted to make it easier for people to access the type of support they need. In 2007 DPT developed a new way of providing care across the county and categorised care according to the different kind of mental health needed which included:

1. Access to wellbeing and mental health services providing a single point of access to services using the principle of least intervention first time
2. Urgent and in-patient care – to provide an urgent care response to those experiencing a mental health crisis
3. Recovery and independent living – to ensure that people receive the support they need to recover and maintain their health.

4.2 Working with partners

Devon has a dispersed and diverse population which the DPT unified in its commissioning framework, creating four 'networks, each covering a different geographical area. In these areas, all mental health services, regardless of who provided them, were brought together. Fortunately in Devon the DPT, the PCT and the local authority are co-terminus and so there are joint commissioners for health and social care. It has become widely accepted that coterminosity is key to effective cross agency commissioning and delivery – and will be critical to the Coalition government's new Local Enterprise Partnerships.

The role played by the joint commissioner was described by all players as extremely active in its leadership role, reaching out to third sector partners and giving them the opportunity to engage with statutory partners:

'Having a joint health and social care commissioner has helped us build a shared vision. For the voluntary sector partners that gave us the confidence to get involved. We have different groups of people to serve and sometimes we'd struggle to provide a shared response with a statutory agency that might see their role one way while we'd see it in another way. Previously, we were sceptical. The fact that we've been able to get all organisations, people using services and clinical leads signed up to these shared ways of working means that the problems are possible to overcome. It's the joint commissioner who led the way and who achieved consensus.

The fact that all partners engaged in discussions about how to develop recovery practice resulted in a shared statement of recovery values, principles, practices and standards set out in a recovery guide. This guide has been widely adopted in the county, and provides a common framework for the way that care is to be commissioned. The development of shared vision and practice was helped by the commissioning relationships across the County which were very stable.

'Those voluntary sector partners that have found it easier to thrive and be part of the networks have had very stable network relationships. I've had a contract manager with a relationship with the PCT for 12 years. I would say that's crucial. Those organisations that haven't had that have struggled to be part of this'.

The debates between organisations with very different perspectives were described as very challenging at times. The quality of the personal relationships that have developed between organisations has provided an environment within which differences can be aired and perspectives shared, leading to the development of a shared vision that all those involved felt able to commit to.

'If you have a relationship based on trust and mutual respect you can have the challenging conversations which we had to have across the system to enable us to make progress. In the absence of that trust this is more difficult. I observe all the time when people feel comfortable debating the issues they are also more comfortable in disagreeing, which is very creative... A lot of the people here have known each other for maybe 20 years… There is a trust which comes from long standing relationships and shared values'

Devon partners have contributed to restructuring and have helped to reshape the service and develop ways of working that best enables the network, rather than individual organisations, to provide recovery-focused care.

What difference does a collaborative approach make in practice?

'In the past, we would have needed a contract in place for someone in residential care. This would delay care. People need to be able to ring up and come straight in. So we found a new way. The person can manage their care and we'll sort out the money behind the scenes. If you're a care coordinator you are now released from a large chunk of administrative work. If you are a person using our services you know who to ring up and talk about what you need. We've achieved that by having the various commissioners agree what is recovery-orientated practice and put people in the driving seat. Remember, these are people with quite complex needs and you have us who are prepared to be flexible and either work with people at home, or give them a bed for the night or have them with us for a while according to what their needs are, but they can negotiate that directly with us. We would regard this way of working as being recovery supportive. And it's very different to what happened before.'

The DPT ethos and strategy legitimised those practitioners who were already collaborating with other agencies to provide 'recovery' training for staff and to organise work opportunities, housing and personal support for service users and alert them to existing social networks. DPT adopted a network model of organisation to make such collaboration easier and stimulated more informal relationships with staff and service users. Networks are integral to the Trust realising its broader vision of inter-agency public service collaboration. Each network is informed by a professional expert group (PEG). The DPT spirit of collaboration has generated a high degree of trust between staff and services-users, which has improved professional judgment in both service delivery and commissioning. This has radically changed professional attitudes and resulted in much more nuanced assessments of patients by clinicians, the latter now can call on the experience of services users which has enabled them to be able to differentiate more effectively between those who need continuous support and those who need intermittent services. This more open and confident dialogue has led to more authentic relationships which motivate both staff and patients to change in their views of each other – the boundaries between them have been blurred. The experience of mental illness continues to be daunting but the confidence to articulate feelings and thoughts was evident in the network meetings that Devon service users attended.

All comments are by Alison Moores, Chief Executive, Community Care Trust (South Devon) in interview with Sophie Hallam, 2009

4.3 What people want from mental health services

A workshop with those using Devon Partnership Trust's mental health services came up with a list of 'things' that they needed from service providers to support their recovery.

- **Acceptance** – active listening to find out where someone is at that point, accept it, and tailor approach accordingly
- **Hope** – a sense of optimism that things can get better and working towards whatever that might look like. This can either be together or, if the person is too unwell, perhaps someone might undertake to carry that sense of hope until the person is well enough to take it up themselves
- **Flexibility** – putting the person's needs first and 'working the system' so that it responds to their needs, rather than making the person fit the system's needs
- **Risk** – not allowing fear of 'risk' to get in the way of making judgments about how things seem at the time
- **Control** – working in partnership so that the person using the services has a shared role in shaping their own treatment.

The Trust is now involving the mental health network in its own strategic thinking and making sure that those with first-hand experience of mental health difficulties are represented on all professional and clinical advisory groups. The Trust organises public meetings and events to discuss what recovery-oriented services mean in practice and view the prospect of foundation status as an opportunity to develop a more diverse governing body.

'It's unusual to think about doing anything which is about reviewing or developing our services without having people with lived experience as part of those discussions. Sometimes we don't always get it as right as we should

19. 'Beyond the Storms, Reflections on Personal Recovery in Devon' is a collection of personal thoughts and reflections drawn from a wide variety of people across Devon edited by Laurie Davidson and Linden Lynn and published in 2009 by the Devon Partnership Trust.

do – but then people can tell us that we haven't got it right and we take that on board and work on improving it. Our ambition is to broaden the range of people who engage with us – but a bit like the journey that we've had to come as practitioners it's not until you get the benefits of that, see that what you're doing is really changing things, that makes the difference'.

Liz Davenport, Director of Operations, DPT

The Trust views 'recovery' as an important part of their 'wellbeing services' and publish people's stories like '*Beyond the Storms, Reflections on Personal Recovery*' as a way of showing what the process of recovery involves[19]. The following account is from one person who thought that the approach had helped her manage her life and move on.

'It's hard to pinpoint when my recovery began. It might be when I was admitted to Haytor psychiatric inpatient unit. There the staff were so different: accepting, understanding. The OT who welcomed me apologised for searching my bag. The registrar was thorough, kind and found some common ground - we'd both studied at the same university. One of the nurses chatted to me for ages, helping me to challenge my negative thoughts. When I got home the CPN was fantastic…. What really made a difference was that the staff accepted me as a person they didn't judge me and listened; my medication did help me sleep. I was lucky because my family accepted me as ill and loved me just the same. Later I was able to negotiate discharge with my psychiatrist and the hospital chaplain also helped me love myself."

Haytor Seat, Dartmoor

4.4 Employing peer support workers

Working closely with and employing those with mental health experience was central to the DPT strategy so that the user experience was understood by all staff. The Trust had in 2009 undertaken a survey of all employees to find out how many of had experienced mental health problems and whether they felt able to share their experience with their managers. 23% responded. Of these, 43% reported having mental health problems themselves, with about half having received some form of treatment; 61% had friends or family with mental health problems. Positively for the trust, 66% felt that they could talk openly with managers and colleagues, but those who did not said this was because they were afraid of being stigmatised. A significant number felt that, in spite of the recovery policy statement, mental illness was still something you kept quiet about and that there was still a 'them and us' culture at work. The Trust followed up this survey with a number of actions including conversations with staff on wellbeing, skills development in expressing personal experience and a new 'healthy workforce strategy'.

4.5 Motivating staff

The Trust originally motivated staff by identifying what needed to change and described the process by the three R's – Review, Relationship and Recovery.

'Everybody in the organisation understood that that's what we were focusing on and could think about how it related to them. So from a workforce point of view we started thinking about what does that mean about the sort of people we employ? Both in terms of skill and knowledge, but also attitudes and behaviour they have which would support or not the recovery agenda. What is it about how we describe to our staff what our expectations are of them and their jobs and how we set their objectives and how we review their performance?'

Liz Davenport, Director of Operations, DPT

The DPT offered various training options on 'recovery' for staff such as, *'In my shoes', an induction training programme, Support Time and Recovery (STR) foundation training and Recovery Co-ordination master classes.* However, a review in 2009 acknowledged that training impact was weak and its delivery

unsystematic and that, to have an impact, training needed to be assessed by how far those using the services experienced a difference.

'We see this quite often … when you ask people to think very differently about what they do, I think that offers even more challenge. Particularly where some staff perceive they'll lose that bit of control that sometimes helps them feels very safe in their jobs. And I think that's one of the challenges and where we've not made as much progress.'

Liz Davenport, Director of Operations, DPT

Managers recognised that the Trust's training needed to be scaled up to include more staff and address the ongoing need for supervision and coaching to help embed changes in practice. To improve training the Trust developed a recovery training and development strategy to be rolled out over the next three years. This set out 6 levels of activity: induction, foundation, training the trainers, role specific training, leading recovery in practice and coaching for improvement.

Those involved in the Devon Networks emphasised the importance of longstanding relationships between service users, staff and other agencies. Networks attract those who want to improve their lives and the range of services on offer in the county to mental health sufferers. While the Trust benefitted from long standing relationships which assisted partnership development, it was also a source of resistance to change. Changing the culture in some teams remained difficult because many staff were set in their ways.

'In this organisation some have been here a very long time, patterns of working have been around a very long time. I think we have a lot of work to do to make people feel confident enough to change and we can take a real lead from organisations like [the Care Trust] where a lot of work has already been done'.

Liz Davenport, Director of Operations, DPT

4.6 Activities to support mental health recovery

As well as providing training to generate new ways of working, managers also asked Human Resources to redefine recruitment processes, job descriptions, and performance reviews as ways of redefining roles and articulating more clearly how staff could develop their practice to support people's recovery. The Trust also wanted their front-line staff to change their attitudes to mental illness and to service users. This was challenging.

DPT clinicians encouraged staff to use their own experiences of mental distress to inform their work and to change the team's behaviours, some of whom had been employed 15 or maybe 20 years.

The DPT partnership has stimulated:

- Networks for those with mental distress which are inclusive of staff
- Regular contact and strong involvement of those with lived experience in design of services and commissioning
- Story telling is used as a tool for self-expression and has led to publications such as Beyond the Storms.
- Personal-assessment and the widespread adoption of recovery plans
- Regular conversations with service users on how they would measure success, and what helped them
- Surveys for management data

'If you only focus on the numbers of assertive outreach people in your caseload, or the number of people you engage through a crisis resolution service, you may tick a box but you'll achieve little else. Our philosophy is that if you focus on the people who use your service and do the right thing for them, you'll also be able to hit the target - and achieve so much more. I think that deliberate attempt to refocus what we do in that way is incredibly powerful. [But] it scares the living daylights out of the people who monitor our performance.'

Liz Davenport, Head of Operations DPT

'But the reason I emphasise the fact that decisions have been made on their merits is because it's not been nepotism or sloppy thinking or favouritism or anything like that, these things have all been hard argued, evidenced with sound rationale and so on. But there has been goodwill and trust which have come from long-standing relationships and shared values which have survived people moving jobs.'

Glenn Roberts, Consultant Psychiatrist, DPT

The number of people classified as service users who attended Recovery Network meetings from Devon were impressive and a testament to the commitment to 'recovery' among some key practitioners in DPT. However, some practitioners thought that for the recovery approach to be properly embedded in mainstream services it has to be seen as part of the 'wellbeing agenda'. There was some concern whether the adoption of 'recovery' within official policies such as 'New Horizons' would perpetuate the false divide between those who are seeking quality of life and 'wellbeing' and those stigmatised as mental patients seeking 'recovery'.

For additional reading about this work, visit:
www.devonpartnership.nhs.uk, www.recoverydevon.co.uk.

My wellness tools – what works for me

Work –
Being productive, making things and using my skills

Homemaking –
Nesting, holding together creativity and safety

Contemplation –
Study, thinking, writing, reading, talking, teaching

Medication –
Antidepressants and sleepers

Authenticity –
Valuing being real more than being comfortable

Apologising –
Accepting I can get it wrong – saying sorry

Tenderness –
Being open to moments and places of real connection

Honesty –
With myself and others – saying and facing things

Practical usefulness –
Doing anything that needs doing

Giving –
I feel better for giving or seeking to be mindful of others

Prioritising –
Ordering, scheduling, listing, cancelling, delegating

Kindly realism –
Expecting less of myself so I can succeed when low

Humour –
It can be a relief to find my own seriousness funny

Accepting –
Present realities, my own state of mind and it takes time

Decluttering –
Tidy up, clear out, clean up, mend or throw away

Sustaining hope –
Believing it will pass, it has been and will be good

Adventuring –
Experiencing the world as much bigger that my horizons

Creatureliness –
Being with, absorbed in and part of nature

Taken from Beyond the Storms edited by Davidson and Lynn and published by the Devon Partnership Trust 2009

5. South West London and St George's Mental Health NHS Trust

5.1 Leadership and strategy

In London, where the South West London and St George's Mental Health Trust (SWLStG) covers an area of 9 London Boroughs, the approach set out in the strategy is one of defining three components by which 'recovery' can be understood, defined, and measured. Judy Wilson, Chief Executive of SWLSTG proposed to the Board in July 2009 that they develop a whole new service model for adult mental health which made 'recovery' central to all their services.

The Trust recognises that everyone with mental health problems faces the challenge of retaining or recovering a life that is as meaningful, satisfying and valued as possible. The purpose of the Trust is to help people with mental health problems to do the things they want to do, live the lives they want to live and access those opportunities that all citizens should take for granted.[20]

SWLStG states that 'the primary purpose of the Trust is to promote recovery and facilitate inclusion'. Rachel Perkins, Director of Quality Assurance and User Experience was a long- standing champion for the recovery approach; employed by the trust in 1987 she remains a national champion for 'recovery'. She was responsible for helping the Trust define strategy, and design and deliver new services, such as training, 'return to work', employment placements and recruitment of peer support workers in the Trust. She resisted the Board's request that a strategy be developed 'quickly' in the early years and worked hard to involve local partners and gain the confidence of the professions.

She and Sue Denby wrote the report[21] that explored new options for adult services in response to demands for personalisation, choice, and self-management of care and the promotion of 'recovery'. This became the basis for radical change and the development of recovery-oriented services in the Trust. The meeting of minds between the new Chief Executive and Board, and long-standing advocates of 'recovery' such as Rachel provided the leadership and persistence necessary to make the 'recovery' process visible and help staff understand how they could contribute to it. Long standing champions of the

20. SWLStG Strategic Plan, quoted in the Recovery and Social Inclusion Strategy
21. Re-visioning Community Mental Health Services; Perkins and Denby SWLStG, 2008

recovery approach were keen to demonstrate the value of 'recovery' and it was clear that the persistence and energy of recovery champions such as Rachel had been key to the Trust's adoption of the recovery approach.

5.2 Activities to support wellbeing, connection and care

A drop in centre had been set up to encourage open access as well as strong links to training and employment agencies. In 2009 the Trust opened the Wandsworth Recovery Centre, giving visibility to the approach as well as open access to local people. The Trust also set up a number of initiatives to involve service users so that they could work with other people as well as develop personal management skills. Many of these new initiatives are part of the national policy to Improve Access to Psychological Therapies (IAPT) and to provide early support for those common mental health problems.

The Trust proposed five tiers of services that provided open access at the primary level as a way of de-stigmatising access to mental health services. New roles for recovery support workers (STRs) were established within level three community teams and referral clinics were held in a number of locations with more specialist clinics for more acute and difficult problems. The recovery teams were based in local areas and contained mental health specialists from a number of services as well as peer support workers. The community health teams provided recovery-focused support and guided people through other services such as housing, training, benefits or community organisations as well as offering new activities. These included a number of initiatives to involve those with mental health experience including:

- A Service User Network – led by those experiencing personality disorders
- Peer support on adult wards as well as in community teams
- Challenging behaviour teams
- Longstanding self-management programmes
- A User Employment Programme
- A New Recovery Centre
- Storytelling (a technique used in this and many other Trusts)
- Publication of personal recovery stories

The Trust hoped that the combination of good service access and the creation of recovery support teams would result in a reduction in the need for of qualified professionals who then would be freer to develop new services and engage with commissioning and therefore become change agents. In the past the trap of mental illness is that people became patients for life and clinicians for that person understood their role only to be engaged in clinical treatment. Those with recurrent episodes of mental distress may not require the support of clinicians between crises. What people want to know is who to call when they need help.

Those in crisis are supported by specialist teams who operate between specialist, intensive treatment and in-patient care, and work closely with consultants. This whole system approach was presented by the Trust to clinicians and managers in several workshops in an attempt to overcome tensions. These provided an opportunity for staff to offer their views on issues such as burn-out of staff, future support and communication problems between tiers.

"In 2003 I was diagnosed with Bipolar disorder and soon after made redundant. I received excellent treatment but when discharged I was unemployed for 4 years… Then I volunteered for a year and was invited onto the User Employment Programme and joined job club, gained in confidence, attended a prep course and was placed on a ward for work experience . Later I applied for a job at Springfield. Starting work brought abundant benefits and I manage my moods with medication. Work has improved my health and I am less depressed."

From Voicing Views Newsletter Wandsworth 2009

Sammie's Recovery Poem: Together We Stand, Divided I Fall

Don't get confused!! Together we stand (i.e., me and my personality) and divided I fall (i.e. my on my own without my personality)

Together we stand
Divided I fall
Whatever the plan
Hits a brick wall
Can't change my mind
When it goes wrong
I see warning signs
But doesn't hold strong

Won't feel the pain
I'm not under pressure
Tripping in the rain
Might make it better
Because life hurts
I take the risk
Putting others first
Ain't a healthy mix

Sometimes I forget
When to stop
And I'll bet
Mouths will drop
I'm faster than light
But slower than time
If this is so bright
They're left behind

No matter how quick
Today or tomorrow
It makes me sick
That feeling of sorrow
And over the years
I've learned to cope
So when there's tears
I know there's HOPE

Taken from South West London Recovery Stories December 2009

5.3 Changing attitudes

The emphasis in St Georges is on involving staff in how 'recovery' should be adopted within the Trust, developing practitioners' own ideas of what it means for their practice and providing constant feedback on how the Trust and their team are doing. The strengths of the approach are that progress towards recovery is made tangible and specific and its acknowledgement that recovery relies on the quality of individual relationships; that individuals are best placed to shape their practice in response to the person they are working with.

St Georges' focus has been on determining how staff should behave in the future and on what was needed make recovery focused practice real. To do this the trust tried to:

- Develop a shared ownership of the recovery strategy – staff widely involved in developing it
- Encourage staff to change and develop their own practice – supported by recovery training, recovery champion peers and ongoing opportunities to reflect on the progress and barriers they experience in developing their practice
- Make their progress towards recovery very tangible and relevant to individual teams - through surveys, quality assurance methods and the dissemination of monitoring to the community-based, adult team level.

The challenges of this approach include the time taken to successfully engage individuals in wanting to change their practice and understanding how to do it. There is a degree of discomfort and uncertainty for practitioners and their managers in allowing individuals the space to develop their own practice. This can feel risky. In trying out new approaches some people will get it wrong some of the time as they discover what new approaches work best. Those staff who participated in recovery training were encouraged to describe their own experiences and to reflect on these which had, in some instances, a dramatic effect and left them far more appreciative of the experience of mental disorder.

'A staff nurse had adapted an exercise to help people find a sense of hope. She'd found that if she asked them to write down their hopes it had not worked. But she had more success when she changed her approach when she asked people to talk freely and focus on helping others and ways in which others could tackle problems.'

Interview with clinical manager by Sophy Hallam.

The Trust introduced an extensive staff-training programme which was universally available. It aimed to help staff understand how to have a positive impact on the hope, control and opportunity experienced by those they work with. There was a longer course for managers in which they developed a plan for how their teams would implement the recovery approach. The Trust has a 'can do' attitude, and the very persistent and focused training which supports 'recovery' is embedding a change in attitudes among community-based mental health teams. Initial training is supported by ongoing follow-up sessions to encourage staff to reflect on their progress, share experiences and get help in developing new approaches where they are stuck. The Trust is also developing a cadre of 'recovery champions' within teams so that there is ongoing access to expertise and support.

5.4 Recovery support workers

The Trust had employed service users for some time and was aware that 25% of their own employees had experienced mental health problems. Its report, Making a Better Life Together (2009), recommended that each community support team include a peer who had been through periods of poor mental health, to be known as a recovery support worker (STR). Their specific role would be to focus on the needs of service users and to be advocates for the voice of mental health sufferers. The Trust referred to studies that showed the benefits of employing STRs shown opposite:

IMPACT OF RECOVERY ON SERVICE USERS	
INCREASED	**DECREASED**
self-esteem, self image & hope sense of control involvement with others quality of life problem solving skills employment	risk of relapse hospitalisation inertia symptoms alcohol use poor physical health social exclusion

In order to develop a critical mass of employees with experience of mental distress in the Trust, in late 2009 they developed a training programme for 'peer support workers' and negotiated discrete roles for them so that they were acknowledged by HR as part of the Trust's workforce. They plan, as their next stage, to create a learning academy for peer support workers so they can progress in their careers within the Trust and the wider health service.

5.5 The role of evidence

The National Patient Survey of 2004, which found the Trust to have very poor patient satisfaction levels, galvanised SWLSTG to create their own patient satisfaction survey. This has provided them with valuable data on how far Community Mental Health Teams (CMHTS) are adopting the recovery approach and how each local team is doing. They have developed ways of monitoring progress which assesses patients' feelings of how far the Trust has helped them improve their lives and their sense of hope, control and opportunity. Each team fills in details of responses from all service users on a regular basis as part of their recovery care plans and these are sent back to

the Quality Assurance Manager – teams are assessed on the basis of these. This is part of the Trust's quality assurance process which enables the Trust to benchmark its progress against other Trusts. Feedback on performance is given regularly down to team level (with team league charts) so that staff can see what progress they are making and set this in the context of what is being achieved elsewhere.

6.0 SLAM – a further case study

In South London and Maudsley NHS Trust (SLAM), David Blazey, a recovery project manager, has helped staff and students develop a wide range of innovative ideas for projects which can support people's recovery. One included a soap opera called Riverscross which was conceived and written by young people in the Snowsfield Adolescent Psychiatric Unit at Guys Hospital. With the help of specialist company Spanner in the Works, the soap opera was filmed using professional actors and presented at a showing. Staff felt that there were significant positive changes in the behaviour of some of those involved.

'For residents living within the confines of the hospital who may be feeling isolated the approach is a means of "connecting with the outside world" while creating a new world' says John Ivens, head teacher of Bethlem and Maudsley Hospital School. 'The format allows pupils to explore new techniques and experiences, develop characters and plot their adventures within a carefully structured environment' he adds. 'It is also a chance to look at life from other people's perspectives' suggests the organiser of Spanner in the Works. 'For instance, a pupil may play the character of a doctor which is a contrast to their real lives where they are the ones being cared for'.

Setting the scene for recovery, Kate Oxtoby – Interview with Sophy Hallam, 2009,

Dr Jerome Carson, working in the community in South West Lambeth, has explored a project-based approach to supporting people through their own recovery. Projects have included

- A book with Gordon McManus, called From Communism to Schizophrenia and Beyond;
- Providing an opportunity to stage an art photography exhibition called Seeing Through Psychosis by Jane Fradgely;
- Finding a venue and funding for the performance of a play called St Nicholas by Matt Ward and
- Helping to win funding for commissioning a film about the experience of recovery from Michelle McNary.

Dr Carson also instigated a recovery group which meets regularly with speakers drawn from within the group itself with whom he works to help them identify and shape a presentation on topics they have a particular interest in.

In a focus session with a recovery group, paticipants noted some aspects of Dr Carson's approach which were particularly identified as having helped people in the group recover. These included:

- Focusing on the positive and communicating a genuine interest in people and a real belief in your potential to have something valuable to share with the rest of the group (Confidence in people's capacity to change)
- His ability to network, particularly among his patients, putting people in touch with each other where he feels they share common interests. (network skills)
- His boundless energy and initiative and inspiration transfer itself to those around him (passion and commitment)
- He keeps lines of communication open (blurs boundaries)
- He isn't constrained by having to 'play by the rules' (breaks rules)

The significance of his approach has been recognised by many others.

22. Leading Innovation – Change you can believe in Maddock 2009, National School of Government

7. How to Embed 'Recovery'

7.1 An overview of the innovation journey

Implementing recovery-oriented services, like any scaling of public service innovation, demands leadership, behaviour change and the operationalisation of systemic change within corporate functions and services. We concluded that an essential part of driving the adoption of the recovery approach was an understanding that the process was a journey; started with the vision of a movement, followed by early adopters, who persuade a wide range of others in policy, governance and professional bodies that the approach could benefit the majority of service users. They are joined by those in the mainstream or new services who drive to change the patient/practitioner relationships by creating new services or transforming existing services through various interventions such as staff training, joint practice, incentives etc.

The role of leaders and champions is clearly significant, both in terms of their own qualities and skills, but also in their strategies and ability to be flexible as the landscape changes.

7.2 The role of champions and leadership

The case-studies outlined in this report and others noted show that those in executive positions have a particular role to play in orchestrating partnerships, working, across agencies, with professional bodies and in motivating staff.[22] In each case particular people were recovery champions who were part of a wider recovery movement, these people had worked in other countries and were bringing back innovative approaches and had credibility with the Trust's executives and Board leadership.

The adoption of recovery values and principles at Board level meant that it was possible for 'recovery' to become central to the Trust's decision-making and working relationships with other agencies. Executive leaders were also innovative, and transforming of organisational practice and inter-agency work – collaborative and outcome focus was at the heart of each Trust's practice. They had persuaded not only their own Boards but were also active in external change strategies to persuade their professional bodies/colleges and health officials to endorse 'recovery'. By 2009 both Trusts had

become active in strategies to involve other agencies and service users and staff. In pursuit of their aim to embed recovery-oriented services, strategies and operational leaders were adaptive in their approach to change and had good relationship with their Trust boards. They recognised the importance of partnership with voluntary organisations, social enterprise, primary care, social services, housing, the police, job centres and colleges if they were to create the opportunities that mental health users required if they were to recover.

7.3 Leadership innovation strategies

Our snapshot of the Trusts was only one part of their innovation journey which had been started many years earlier by recovery champions.

At the structural and organisational level in South West London the recovery approach was not a stand-alone intervention, it was understood to be part of the Trust's corporate strategy and integral to mainstream management. The Trust systematically incorporated 'recovery' into all its management functions including HR, performance appraisal and training. This approach enabled the Trust to relate more effectively with its own community mental health teams in each borough. All community mental health teams received training in 'recovery' and were assessed on how far they had adopted recovery principles and recovery care-plans. In 2007, after reorganisation the Trust established cross-agency working and individual recovery plans. SWL&STG were more systematic in their approach to integrating 'recovery' into internal management practices, while user networks appeared less integrated.

The Devon Partnership Trust (DPT) established a level of trust across agencies which is unusual and perhaps reflects a rural environment where staff turnover is low. Continuity of professional relationships in Devon has led to considerable mutual adjustments. The DPT had adopted a network model of organisation, inclusive of the third sector, as well as service users. DPT's strategy relied on the growth of networks and partnerships which blurred the boundaries between staff and service users. The network of service users across the county has informed professional and commissioning judgments about service design, new services and importantly about clinical judgements. DPT appeared to have developed a form of distributive leadership across agencies and were not afraid to blur professional boundaries in order to be

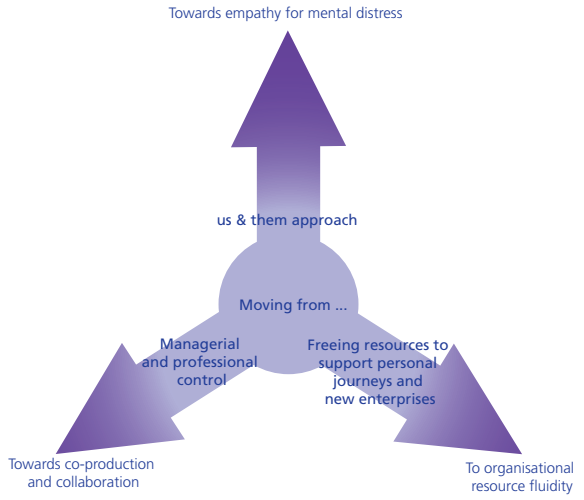
more effective. They have created an environment where new relationships across agencies and with staff and users could develop. However, some DPT managers and clinicians are aware that their approach had led to less systematic training and data collection.

Each Trust demonstrated a whole system and place-approach to their work, which was focused on developing more nuanced commissioning and as well as holistic services. This is highly relevant both to the current Department of Health's agenda of decommissioning to GPs and the Communities agenda of 'localism' and strategic commissioning through the Local Enterprise Partnerships (LEPs).

The findings show how those with very similar objectives can have very different implementation strategies. Developing effective and real external networks which involve service users and transform back-office functions at the same time is a difficult trick to pull off even for the most exceptional of leaders.

Embedding radical new practices demands a strong and an active 'user' voice which sometimes cuts across systemic procedures, because new practices need space to develop. However, without some systematic translation of these into mainstream practice they are unlikely to sustain beyond the life of powerful champions.

Embedding the Recovery Approach
Su Maddock, 2010



7.4 Developing capabilities

Given that many years had been spent on arguing for 'recovery' and that Trust boards had adopted 'recovery' as part of their vision, the focus of all interviewed was now on their strategies to implement recovery oriented services, which involved looking to find ways of achieving a participation of staff, whether clinician or carer in the adoption of 'recovery' in adult services. Changing staff attitudes and behaviours has been recognised as central to any public service innovative implementation and more innovative policy making.[23] This is largely because the tradition within caring services to provide a form of care that is closer to containment than recovery is no longer appropriate and runs against 'recovery' principles. We agree with NESTA that *"Innovators in all services have to struggle to change the rules"* and that leaders have to support those actively transforming practice in order to render them more responsive to innovation. (NESTA 2010)

Those involved in implementing an innovation such as the personalisation approach of 'recovery' to have a capacity to

- Emphasise and be open with colleagues and patients
- Collaborate with other agencies and patients as equals
- Focus on inner resources of themselves and patients
- Introduce hope in the future in patients
- Be flexible in how they work.

The study's findings also confirmed Borg and Kristiansen[24] and Perkin's[25] research which came to similar conclusions. The question for Trusts is how to shift staff behaviour in the future. Professional training has already made many of these aptitudes integral to much professional training. The challenge for professional development organisations is in finding the right ways of delivering training such that it helps staff change their behaviours. Interestingly, recent research shows implementing recovery in mental health settings depends as much on the quality of line-managers or team-leaders as on development training.[26] If team-leaders do not endorse more innovative behaviour then even those who have attended courses will find it difficult change their relationships with service users.

23. Maddock, S Leading Innovation – Change you can believe in (2009) NSG

24. Borg, M & Kristiansen, K (2004) Recovery oriented professionals; helping relationships in mental health services. J of mental health, 13, 493-505.

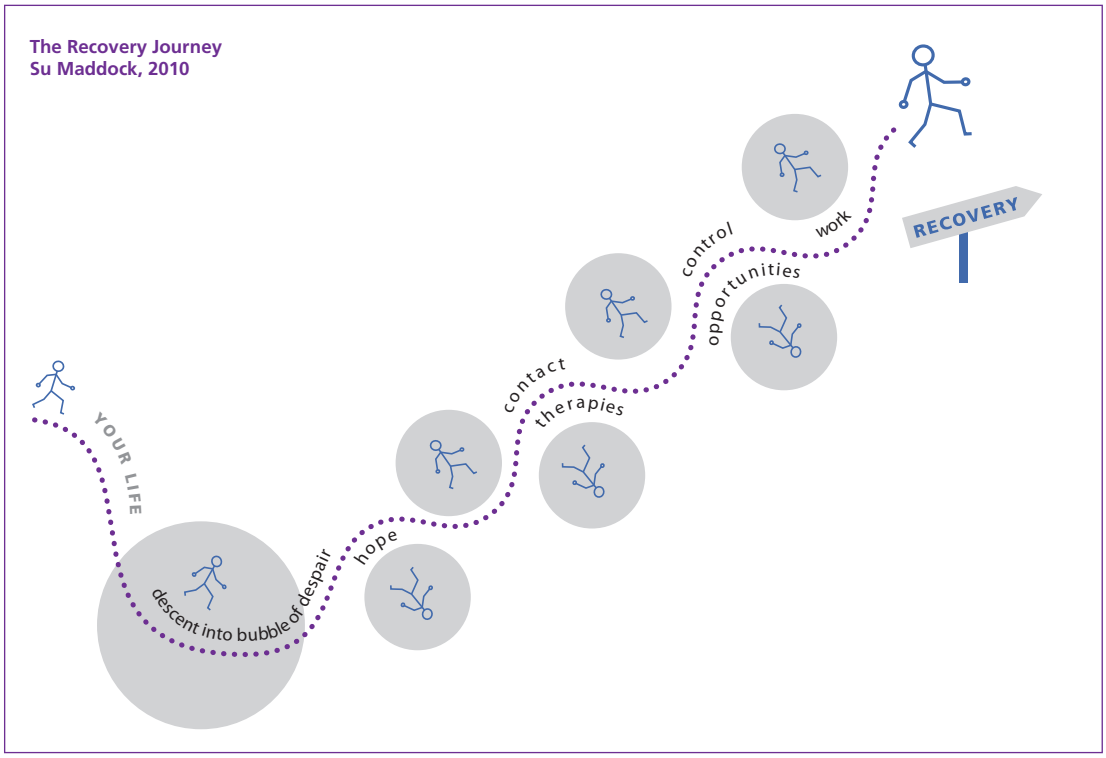
25. Re-visioning community mental health services; Perkins and Denby SWLSTG 2008.

26. Implementing the illness management and recovery programme in community mental health setting; facilitators and barriers. Whitley, R et al Psychiatric Services Vol 60, No 2 (2009)

Ultimately, implementing 'recovery' is about changing the way staff work with those defined as 'patients' or 'service users' this means changing working practices and being open to new ways of working. Leadership is key in providing the mandate for changing roles and rules, to support culture change, all recovery champions agreed that a critical mass of 'peer-support workers immediately gave rise to real change in other staff's thinking and practice. In fact, when both Trusts surveyed their staff it became clear that a significant number of existing staff had had experience of mental distress.

7.5 The innovation journeys

Evidence from these and other studies show that the innovation journey is unpredictable, oblique and multi-faceted. However, what can be said about the personal journey from illness to wellbeing, is that it is greatly enhanced by a belief in recovery, the support of peers and from practitioners who



create opportunities and work in a cooperative way. At the onset, peers who understand the experience of mental illness and have themselves been through recovery can make a real difference to a person's confidence in the recovery process. This confidence can be easily undermined by unthinking staff which is why the implementation of the recovery approach is so closely connected to staff motivation, training and openness. Some people will have recurrent episodes which they learn to manage through the recovery process and the support workers who become more open to self-directed management and care.

Running in parallel to the personal journeys are the journeys of those radicalising mental health services. Some of the innovation champions in this study had been championing 'recovery' for many years - for some it had taken years to reach a stage where the professional and NHS climate were open to recovery principles. By 2009, the innovation journey for the recovery approach in mental health had reached a stage where it became integral to health policy for adult mental health services. The Coalition government has taken up the baton and agreed to fund recovery champions and facilitate implementation across many more NHS Trusts.

Neither the innovation or the personal recovery journey follows a set course – the principles of hope, personal control and need for opportunities appear to apply not just to mental health services but to personalised services in general. However, asking for a recipe for scaling up this innovation is to miss the point. Each person and innovation champion respond to the opportunities presented to them and are thwarted by the naysayers they encounter. Looking back and seeing a path does not mean the same path can be followed by another person or another Trust. You cannot precisely predict what will lift a person, except to say warmth and connection will help. In his book 'Obliquity'[27] John Kay shows describes how people are often fooled by randomness, avoid the detail of life experience and overplay the power of plans and models. He believes that in reality all goals are achieved indirectly through ways we would never have envisaged.

Models are imperfect descriptions of reality and usually based on experiences long past - if we squeeze people into the model rather than listening to their experience we limit their capacity to learn, grow and adapt. Given that the point of recovery services is to be help people find ways of being

27. 'Obliquity – Why Our Goals Are Best Achieved Indirectly', John Kay Profile Books, London 2010

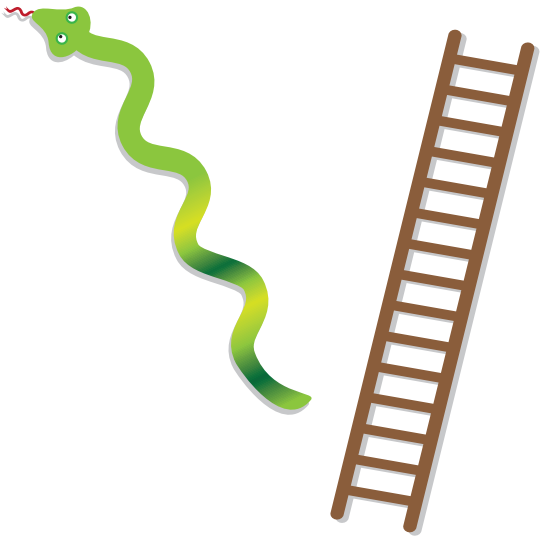


Image adapted from 'Obliquity – Why our goals are best achieved indirectly' John Kay 2010

more resilient we need to help staff become more adaptive themselves and able to develop their confidence that recovery is possible. Those who believe in human potential and in personal change act as catalysts, whereas those more comfortable with the status quo become breaks or barriers to recovery at an individual and organisational level.

Early champions of the recovery approach spent many years persuading their colleagues and senior managers that this was a solution to the pressing demand for much more effective mental health services. Each Trust followed a path appropriate for them, while recognising the common challenge of motivating staff and incentivising new attitudes and behaviour by employing peer-support working, providing training, devising new performance measures and organisational arrangements and starting to embed new practice not just in one employer but in many. This is a never ending process, each agency adapting to new realities and new relationships. In it's implementation the recovery process is having a transformational effect, not just on individuals but on the organisational culture of the NHS Trusts themselves.

This is the beginning of a transformation of mental health services, and is spreading through a growing recognition of the power of more appreciative and empathetic approaches to the recovery of those previously categorised as 'mentally ill'. This is not a scaling up process, but one which policy-makers can support through various measures, such as commissioning, when they recognise the value of recovery principles, best adopted when all practitioners acknowledge:

- the experience of living with mental distress or transition
- the need for self-determination over all support and treatments
- the employment of peer-support staff
- the value of social networks, carers etc as well as clinical treatment

- social exclusion is a consequence of poor mental health
- the fact that wellbeing and illness are a continuum.

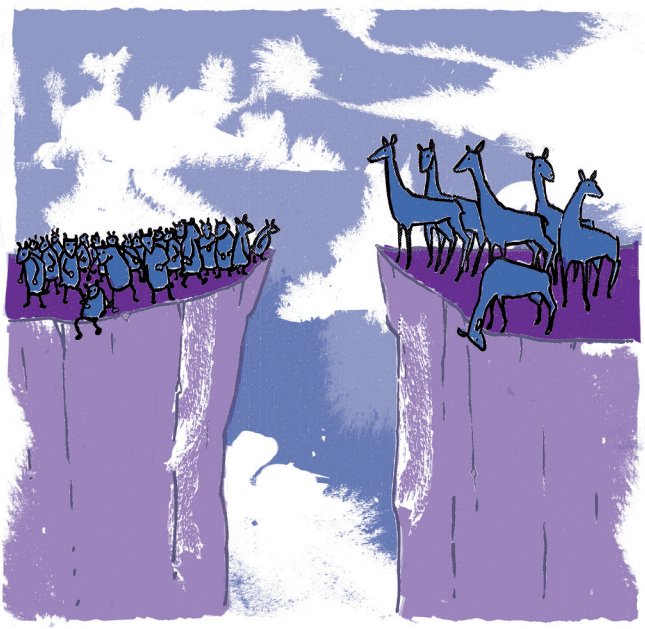
7.6 Making it mainstream

Importantly in terms of addressing the key question of how to move from isolated examples of innovation and to mainstream an innovation such as 'recovery' the following principles are relevant:

- Implementing a recovery approach depends on radical shift in attitudes towards mental illness and those with mental disorders among all staff. Low levels of aspiration among public-sector staff are a major cause of the 'carry on as usual' culture in many public-sector bodies.
- Non-clinical staff in a range of services are important to a person's recovery and a need for more empathy and appreciation and less categorisation.
- Recovery demands that clinical professionals learn to listen to and appreciate the thinking of those suffering mental health problems. This involves challenging professional boundaries and hierarchies. Clinical practitioners need to listen to what matters to people. People suffering mental health problems rarely talk in terms of being 'mentally unwell', they talk instead about feeling angry or let-down.

There is a need for:

- A longer term view of change and people's contribution to it
- Leadership who change the rules, blur boundaries and motivate staff to work outside of their old roles and raise their own aspirations



Bridging the gap between illness and recovery. Illustration: Sam Arthur

- Activities that reconnect staff to services users and the realities of life across services
- A transformation of management and corporate services to endorse recovery practice
- A recognition that radical practice leads to new thinking often not vice versa
- Locality connections through new governance arrangements that reconnect the public to services such as those for mental health.

8.0 From Trauma to Wellbeing

8.1 Successful societies nurture wellbeing

Those countries where citizens feel comfortable and connected are more likely to be able to adapt and overcome periods of personal or economic crisis. In Iceland even the tourist guide has an advertisement on how the country is damaged by every person who is unemployed. This is unsurprising as Iceland only has a population of 300,000 so everyone is important as a resource to the country. Caring how people feel is important in a modern society, and perhaps smaller countries are more attuned to people's needs precisely because the country needs them to be resilient.

While the UK has a much larger population – reversing the trend of seeing service users as a cost rather than a potential asset is one of the barriers to more citizen centric services and why any initiatives that involve people can have very positive effects. Governments of successful societies care about the wellbeing of its people and about whether they have a resilience given the pace of global change.

'The recent recession might have been expected to diminish interest in 'wellbeing'... Instead, it has generated a sharper focus on what public spending does to influence wellbeing, how to make people resilient.'

The State of Happiness[28]

'Recovery' is a process that enables those in transition or suffering from poor mental health to manage their lives and as thus is at one end of the wellbeing continuum. Helping people to recover from mental trauma is therefore not just for relevant for the individuals concerned but also for society as a whole. Believing that recovery is possible is an important factor in those with recurrent mental problems finding a way towards wellbeing. Many in the recovery movement have noted that if the divide between wellness and illness is perpetuated then it is harder for some to recover, as Glenn Roberts below has noted.

"I do worry whether we can bridge the false divide between wellness and illness - one of the core aspects of a recovery emphasis is about the 'recovery of wellbeing' or put even more simply – how to live well – even with an

28. The State of Happiness- can public policy shape people's well-being and resilience? N Bacon, M Brophy, N Mguni, G Mulgan and A Shandro The Young Foundation 2010

29. Personal communication March 2010
30. Putting People First without putting carers second. www.crossroas.org.uk/downloads

enduring health problem. It follows that 'social inclusion' have salience all the way down the distress and disability spectrum in terms of what is possible to integrate within ordinary living and in my view it would be a significant failure of policy and vision if the wellbeing agenda inadvertently disenfranchised those with 'long term conditions' – again – whereas a recovery emphasis is, in my view, inherently bridging and integrative."

Glenn Roberts, consultant psychiatrist, DPT, 2010

8.2 The role of family, friends and 'carers'

Recovery is dependent on a myriad of relationships and connections, particularly of carers, family and close friends. People who are well supported by family and friends are more likely to recover quicker. In the real world, clinical support is infrequent; it is carers and friends who have most significant influence over people's recovery. Little was mentioned by those interviewed for the study about the role of carers, families and friends in the recovery process. Yet, as Julie Repper, a champion for recovery-based services in Nottingham points out, 'We have only just started to think about how to involve the family and friends of those with a recovery plan.'[29]

Sometimes this contact can have a negative impact. Family members and carers can be positive advocates but can also reinforce negative attitudes based on their own experiences and lack of hope in the future. There will be cases where families stifle personal development because of their own beliefs or exhaustion. However, to exclude family and friends from recovery care plans when they are in daily or weekly contact with a person would seem to be counterproductive. This kind of support requires much more effort. The Princess Royal Trust for Carers and Crossroads for Carers suggest that

'We must explore how personalisation can be applied to whole families and communities as well as to individuals, thus establishing new partnerships between the person receiving care, carers and professionals.'[30]

8.3 Connections to place and people matter

Growing evidence is emerging that participation in all social activity or sport is healthy and supports both a sense of belonging and personal wellbeing.

People are healthier when they have social relationships, connections and some control over their lives. Too often people fall off the social radar after a mental collapse making recovery more difficult. There is a strong connection between social exclusion and mental illness and it is very hard to untangle cause and effect. Those who have a 'breakdown' can become more isolated and those who are excluded through poverty, transient life-styles or disabilities are more likely to end up with mental health problems. Mental distress is frequently exacerbated in or after prison, after divorce or bereavement, unemployment or homelessness.

Having a sense of belonging, connection and being respected is important to all of us, but especially at times of stress and transition.

The community is critical of the recovery process and connections locally help people learn to value friendships and introduce individuals to opportunities to regain their confidence through small activities, like making tea etc. These connections reintroduce people to the experience of 'life' and other people and from that experience open up other opportunities that help create a sense of purpose, hope and release from personal preoccupations.

8.4 Recovery principles offer hope to anyone living through trauma

'Recovery' could improve support and services to those undergoing any transition especially if they are marginal and disenfranchised through poverty, ill health or other disadvantage. The recovery approach treats people as human beings and creates opportunities for them to regain control over their lives. At present, mainstream provision in too many services is poor at giving people emotional support and encouragement. The reason why so many personal services fail is that they fail to connect to people and their lived experience – in particular so many services have become a set of activities or tasks and do

31. Best and Gilman (2010) Recovering, Happiness, Drink and Drug News.

not address people's need for confidence and hope before they can even start on a 'learning journey'.

The essence of 'recovery' is in the quality and authenticity of all relationships for those undergoing mental distress, as it is for anyone in receipt of personalised services. Given that these take time to develop it is not possible to organise a six week course and then leave people to their own devices, some will need more time, and others could change more quickly.

The recovery approach could offer hope for so many if implemented in a way which gives people hope in the future – it is not a panacea, translating hope into a change in life style depends on a range of services, and on social networks and relationships. It can have a rippled effect which research and policy-making have been slow to note, for instance, Best and Gilman[31] report that recovery from drugs can generate shared recovery for a group or family as well as for the individual concerned.

8.5 The recovery approach relevant to all personal services

The principles of 'recovery' can be applied to other services for vulnerable people undergoing dramatic transition whether offenders, ex-service persons, sub-abusers, the depressed or bereaved. 'Recovery' could be relevant as a way of improving

- Mental health services
- Adult social care
- Criminal justice solutions
- Support for ex-service people
- NEETS (16-18 year olds not currently in education, employment or training)
- Welfare to work
- Social regeneration

Rethink[32], an agency working with substance abusers and mental health has suggested that recovery depends on:

- A place to live
- Some personal control over lifestyle and symptoms
- Human support and social justice

They suggest that although recovery plans may help – often people with more fluid lives are supported through their recovery journey by friends, peer support workers and positive advocates.

The criminal justice system could be radically changed by an adjustment in how we treat and work with offenders. The Coalition Government's Justice Secretary Ken Clarke announced in July 2010 a desire to reduce the prison numbers in the UK by community based services such as 'recovery' for those given six months or less sentences. This is a positive start but these services do need kick-start investment.

The Coalition Government could redesign offender management with imagination and investment – especially as the capacity for delivering more imaginative support is growing, for instance by, the Calderdale Women's Project, The Eden Trust, CISCO and many other social enterprises.

32. Rethink – Getting back into the world; reflections on the live experience of recovery. www.rethink.org/intotheworld

8.6 The Scottish Government

The Scottish Government has embraced 'recovery' as an approach for working with substance mis-users. In Scotland, an estimated 52,000 people are problem drug users; 40-60,000 children are affected by the drug problem of one or more parent; and there were 421 drug-related deaths in 2006. This has a significant impact on individuals, families and society - with an estimated economic and social cost of £2.6bn per annum.

"The Scottish Government's 2008 Drugs Strategy, "The Road to Recovery," explicitly adopts the model of recovery from the mental health field and applies it to addiction services. Specifically, it promotes the evidence that

33. Road to Recovery: http://www.scotland.gov.uk/Publications/2008/05/22161610/0 Recovery Consortium: http://wiredin.org.uk/users-ex-users/community/blog/entry/7627/the-scottish-drugs-recovery-consortium-goes-live

shows the value of the recovery-based approach, and calls for a shift in the focus of all services to what they can do to promote an individual's recovery. The strategy also commits the Government to set up a Scottish Drugs Recovery Network – this was realised with the formation of the Scottish Drugs Recovery Consortium in 2009. The transferability of the recovery model as a means of promoting peer community and support is now being looked at further in other policy areas, including criminal justice."[33]

The online comments from Scottish Drugs Network demonstrates just how powerful the recovery approach can be

"Recovery is not just a new fad focused on redressing a perceived harm reduction/abstinence imbalance within the treatment system. It is a radical call for person-centred services, focused and delivered within communities (as opposed to being delivered within a weekly hourly session or series of 'structured' groups within a treatment service), with 'transformation' at their heart. These services must be informed and led by people in 'Recovery' and 'Recovering' if they are to be meaningful. Within the context of (currently rather limited) treatment services it is my belief that the 'Recovery' model should be focused around a language of change, transformation, hope, optimism and Personal/Community empowerment. Recovery should not be 'reduced' down to 'abstinence'. Apart from everything else this version of 'Recovery' will simply not be very effective."

On line community of practice 2.7.10

8.7 Future policy and actions

We have a crisis not just of the economy and the climate but also of human resources. The focus of policy should be less on managing institutions and more demanding of personal services that support an individual confidence and capacity to learn and grow – not by demanding 'scaling up' of standard or technical solutions that ignore their particular plight or situation.

The challenge for personal service providers is to be able to reach individuals who were previously known as 'hard to reach' and connect to them, their

experience and ambitions. Often, social enterprise can do this better, but not if they are squeezed into timescales and procedures that service commissioners rather than people. Public bodies need to organise to become more connected to people, to localities and to other community-based services.

The Trusts studied here were beginning to act less as service providers and more as strategic bodies that brokered connections, created platforms for new networks and nurtured more humane practices in service provision. The problem for commissioners is that their own frameworks have been too closely tied with policy-makers' targets rather than on making a real impact on the people the services are supposed to support. This is true in all personal services, but perhaps less so in mental health because expectations have been so low, commissioners have not expected positive outcomes at all.

Recovery Principles:

- Apply to all personalisation innovations that support resilience across service areas
- Demonstrate the connection between mental health, social wellbeing and economic revival
- Are shared by most people working to change public attitudes toward mental health problems
- Could be introduced to locality leaders and LEPS
- Support the Big Society ambition

The Government could support a radical shift in achieving wellbeing and efficiencies by:

- Introducing recovery principles and practice into professional and skills training
- Investing in new ways of measuring well being outcomes
- Supporting all service providers who are shifting their emphasis and personalising services rather then rationalising them.

9.0 Will Recovery Lead to Savings?

34. Schumpeter comes to Whitehall- cuts and innovation in public services.Laura Bunt, Michael Harris and Stian Westlake, NESTA 2010

35. The Human Factor – How transforming healthcare to involve the public can save money and save lives. Laura Bunt and Michael Harris NESTA November 2009

36. Sinking or Swimming Young Foundation Dec 2009

37. Bunt and Harris, Nov 2009

The question of whether the recovery approach in mental health could reduce public spending must surely be yes; but only if the process of implementation invests in the time it takes to develop commitment among staff to work in a more respectful and optimistic way with service users.

Saving money needs to be done in a way that gives space to more of the kind of services we want to end up with. In order to do so, we need to understand more about how the system in public services stimulates and supports innovation (or doesn't) and how to turn the current crisis into a vehicle for transformation.

The costs of not attending to the poor public mental health are high. The NHS spends 14% of its budget on mental health. Treating mental ill health costs the NHS £13 billion[34] per annum and demand for treatment is increasing. The number of people using anti depressants has increased from 9 million in 1991 to 34 millions[35] in 2007. One estimate suggests that the NHS could save more than £6.9 billion[36] by adopting more patient-focused services which enable patients to take on more responsibility for managing their own care. This approach is particularly suitable for people with long term, chronic mental health problems.

Worryingly, the demand for mental health support is likely to grow. The demands on services could escalate further given future job losses and stress.

A recent WHO study showed that depression is 50% more disabling than angina, arthritis or diabetes, and while 90% of those with these physical ailments received treatment, only 10% of those suffering poor mental health were received any treatment or care, indicating how much the demand on services could grow.[37]

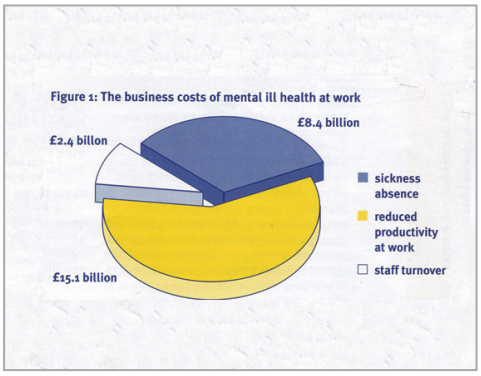
Mental distress also impacts on productivity levels. A government not investing in mental health services and public health is making a false economy. In 2007 the Mental Health Trust summarised the costs to employers of mental ill health among staff to be £26 billion each year. They estimated that £8.4 billion was due to sickness absences. 40% of all absences are due to mental health problems; £15.1 billion was due to reduced productivity when unwell remain in work; added to these costs are the £2.4 billion is the cost of replacing sick staff with agency workers.

At a time when the country is entering a period of severe public-sector spending constraints it is imperative to explore how more innovations such as 'recovery' could radically improve lives and lead to dramatic savings. However, this is not a short term fix. There is a need for new ways of thinking about mental illness, working with service users and conceptualising efficiencies.

All governments have short term expectations and tend to think in terms of financial and structural levers ignoring morale and capabilities. This is misguided and a mistake. An investment in 'recovery' could lead to radically better services which have the potential of generating 'wellbeing' and of providing hope and opportunities to thousands of people currently marginalised by mental illness.

Achieving both financial savings and recovery from poor mental health is not unrealistic. The challenge remains one of keeping the focus on helping people to recover rather than focusing only on the savings. Cuts in budgets need to be selective in a way that supports new practice, transformation and cross cutting work. 'Recovery', like most public service innovation, involves appreciating people's needs and anxieties and improving communication channels, transforming the criteria and transactional mechanisms that underpin commissioning will also support those forge new ways of working and will also generate savings.

The stumbling block to the implementation of the recovery approach in mainstream adult services is a lack of investment in the time it takes to develop staff capabilities that could transform staff/citizen relationships. Some investment in professional training would generate practitioner and public confidence. In an intermediate time period of 2-5 years 'recovery' could generate dramatic savings.



Taken from the Centre for Mental Health Policy Paper 'Mental Health at Work: Developing the business case'

10.0 Future Challenges

- Appreciate the lived experience of the person in recovery and the need for small steps that can support hope, control and opportunities
- Acknowledge the need for more hope and optimism for recovery among practitioners, the public and policy-makers
- Emphasise personal progress and find better ways of recording impact on individuals, organisation and communities
- Find ways of blurring the boundaries between practitioners and carers and community networks. Professionals findings a way to connect to community networks
- Have a positive narrative for the combined force of personal and professional experiences
- 'Stickability' – Staying with people on their journey. Send them a message that they're worth it
- Develop the organisational capacity to support personal recovery journey – developing personal and community relationships as well important as internal staff relationships
- Emphasise the vital leadership role in transforming relationships and principles that underpin culture, eg. training, PM, HR – transform existing corporate services accordingly
- Challenge the channels reinforced by funding etc. and resisting entrenchment into these even when financial resources are short
- Think people and community resources as well as financial resources
- Find compelling ways of engaging with communities
- Shift the emphasis on only service delivery towards creating connections and relationships and acting as brokers and agents of new enterprise, opportunities.

11.0 Conclusion

The recovery approach offers a way of making personalisation something more than choice – because it offers a future based on a person's own experience and opportunities created by services he or she decides they need. This study shows that when staff really work as a group closely with service users they forge new relationships and themselves become more optimistic and open. The recovery approach is a journey towards co-production and mutual support, made possible because practitioners orchestrate support as well as provide 'treatment'.

Public service innovations such as 'recovery' have been slow to diffuse out of small local projects because too little attention has been given to people's experience of trauma and transition and to how to involve staff in the implementation process. Policy-makers continue to demean practice and adopt ideological models and ignore the fact that an investment in people's potential and capacity to develop social relationships would lead to transformational practice, and environments that support well-being and creative learning among staff as well as service users.

The last government focused on the relationships between the public and front-line staff whereas the Coalition government is stressing the need to support the relationships between people in communities. The previous government's policy of 'Putting the Front Line First' was a good one but was not ambitious enough, if front-line staff are disrespectful of the public and have low expectations of new ways of working they are unlikely to be able to engage in innovations such as co-design and 'recovery'. The Big Society has shifted the agenda away from staff and public institutions onto people's relationships with each other as well as with the state. This is good but does not remove the responsibility of government to invest in those who can 'hold the ring' and provide guidance, connectivity and governance between agencies and communities. Innovations such as 'recovery' do not only concern individual agencies and their staff but a plethora of agencies within a locality or city. Imaginative public sector providers can be the seedbeds of new recovery enterprises and with commissioners provide the safe space for new imaginative services to develop.

40. Cloud and Granfield (2009) Conceptualising recovery capital. Substance Use and Misuse 42,12/13

Those in political, executive and local governance positions need to appreciate that those with the most social capital are the most confident and connected, and able to form local associations. Cloud and Granfield refer to a person's recovery capital, and their social, financial, personal and cultural assets[40]; they acknowledge that recovery from any trauma is much harder for people who are mentally unwell, socially excluded have little social or financial capital. The role of the state is not only to encourage mutual organisation but also create the conditions that provide a route into to connectivity and wellbeing for those who are the least resourced and the most troubled. A recovery approach in mainstream services could be one way of achieving this.

Recovery principles of hope, opportunity and control underpin any successful mutual venture and could provide the energy for the transformation of personal services. 'Recovery' is a form of co-production in practice – it's optimistic principles and egalitarian relationships between staff and individual members of the public can raise aspirations among staff as much as among the mental health community. The evidence gathered here from working alongside those implementing 'recovery' is that this is not an easy process, but one which could dramatically improve lives and relationships when staff are motivated and involved because it energizes them. The recovery approach offers a practical approach to changing the relationship between the public and public sector staff and could dramatic improve a whole range of personal services. When the staff/user divide blurs and both come to understand each other better, both readjust.

The recovery approach presses many buttons because it nurtures mutual support within communities and a radical transformation of mainstream public services.

The question is whether the current austerity measures are undermining the capacity of staff to make more personalised services such as 'recovery' possible. When staff are preoccupied with their own survival organisational insularity is more not less likely. The prospect of public sector financial cuts is leading to an entrenchment among staff, which undermines their capacity to collaborate and work across boundaries. This is problematic because innovations such as the recovery approach depend on the capacity of staff to respond not just to service users but also to other staff.

We strongly recommend an investment of time, energy and incentives in recovery oriented services, not only would this radically improve the lives of people living with mental illness it would also motivate staff and save money. We also suggest that recovery services are more likely to create an environment for well-being if they are organised on a place-based approach. The study shows that it is the collaboration between agencies and an acknowledgement of the complexity of local relationships that underpin holistic and seamless services. Collaborative, strategic leaders committed to local people's health and wellbeing could take the lead and commission a wide range of recovery oriented services for all those lacking social capital, experiencing personal trauma or living mental illness.

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